		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008425

Facility Name: Evenglow Lodge

Address: 215 East Washington (Number) Pontiac (City) 61764 (Zip Code)

County: Livingston

Telephone Number: (815) 844-6131 **Fax #** (815) 842-3558

IDPA ID Number: 37-0776135

Date of Initial License for Current Owners: 3/6/57

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Ms. Susan Johnson **Telephone Number:** (815) 844-6131

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Donovan Gardner
(Title) Administrator

Paid Preparer
(Signed) See compilation report (Date)
(Print Name and Title) Mike Hillary, Partner
(Firm Name & Address) Clifton Gunderson, LLP, P O Box 1835, Peoria, IL 61656-1835
(Telephone) (309) 671-4500 Fax # (309) 671-4508

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	73	Intermediate (ICF)	73	26,645	3
4		Intermediate/DD			4
5	141	Sheltered Care (SC)	141	51,465	5
6		ICF/DD 16 or Less			6
7	214	TOTALS	214	78,110	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	9,875	15,366		25,241	10
11	ICF/DD					11
12	SC		24,390		24,390	12
13	DD 16 OR LESS					13
14	TOTALS	9,875	39,756		49,631	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.54%

D. How many bed-hold days during this year were paid by Public Aid?
29 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
meals on wheels

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 3/6/57

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	438,866	40,469	15,586	494,921		494,921		494,921			1
2	Food Purchase		346,858		346,858		346,858	(25,684)	321,174			2
3	Housekeeping	204,124	48,642		252,766		252,766		252,766			3
4	Laundry											4
5	Heat and Other Utilities			226,448	226,448	(19,746)	206,702		206,702			5
6	Maintenance	95,676	34,338	68,348	198,362	(312)	198,050		198,050			6
7	Other (specify):*											7
8	**TOTAL General Services**	738,666	470,307	310,382	1,519,355	(20,058)	1,499,297	(25,684)	1,473,613			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,509,012	62,629	134,991	1,706,632	(1,312)	1,705,320		1,705,320			10
10a	Therapy											10a
11	Activities	74,951	3,477	28,949	107,377		107,377	(10,448)	96,929			11
12	Social Services	25,987			25,987		25,987		25,987			12
13	Nurse Aide Training					1,312	1,312		1,312			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,609,950	66,106	166,340	1,842,396		1,842,396	(10,448)	1,831,948			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			13,960	13,960		13,960		13,960			19
20	Dues, Fees, Subscriptions & Promotions			34,320	34,320		34,320	(14,659)	19,661			20
21	Clerical & General Office Expenses	223,938	15,578	116,726	356,242	(2,533)	353,709	(2,334)	351,375			21
22	Employee Benefits & Payroll Taxes			733,684	733,684		733,684		733,684			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,149	13,149		13,149	(2,534)	10,615			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			165,222	165,222	(14,407)	150,815		150,815			26
27	Other (specify):* bad debt expense			31,989	31,989		31,989	(31,989)				27
28	**TOTAL General Administration**	223,938	15,578	1,109,050	1,348,566	(16,940)	1,331,626	(51,516)	1,280,110			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,572,554	551,991	1,585,772	4,710,317	(36,998)	4,673,319	(87,648)	4,585,671			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Evenglow Lodge #0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			310,250	310,250		310,250	(7,733)	302,517			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,737	48,737		48,737	(48,737)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			358,987	358,987		358,987	(56,470)	302,517			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,967	39,967		39,967		39,967			42
43	Other (specify):* **independent living**					36,998	36,998		36,998			43
44	**TOTAL Special Cost Centers**			39,967	39,967	36,998	76,965		76,965			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,572,554	551,991	1,984,726	5,109,271		5,109,271	(144,118)	4,965,153			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(25,684)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,448)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,733)	30		9
10	Interest and Other Investment Income	(48,737)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(2,334)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,989)	27		24
25	Fund Raising, Advertising and Promotional	(14,098)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,095)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (144,118)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (144,118)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Evenglow Lodge

ID# 0008425

Report Period Beginning: 1/1/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	out of state travel	$ (2,534)	24	1
2	non-allowable dues	(561)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,095)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evenglow Lodge # 0008425 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(25,684)	0	0	0	0	0	0	0	0	0	0	(25,684)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(25,684)	0	0	0	0	0	0	0	0	0	0	(25,684)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(10,448)	0	0	0	0	0	0	0	0	0	0	(10,448)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(10,448)	0	0	0	0	0	0	0	0	0	0	(10,448)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(14,659)	0	0	0	0	0	0	0	0	0	0	(14,659)	20
21	Clerical & General Office Expenses	(2,334)	0	0	0	0	0	0	0	0	0	0	(2,334)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,534)	0	0	0	0	0	0	0	0	0	0	(2,534)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(31,989)	0	0	0	0	0	0	0	0	0	0	(31,989)	27
28	**TOTAL General Administration**	(51,516)	0	0	0	0	0	0	0	0	0	0	(51,516)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,648)	0	0	0	0	0	0	0	0	0	0	(87,648)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Evenglow Lodge** **# 0008425** **Report Period Beginning:** **1/1/03** **Ending:** **12/31/03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(7,733)	0	0	0	0	0	0	0	0	0	0	(7,733)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,737)	0	0	0	0	0	0	0	0	0	0	(48,737)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(56,470)	0	0	0	0	0	0	0	0	0	0	(56,470)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(144,118)	0	0	0	0	0	0	0	0	0	0	(144,118)	45

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Farmer's Home Administration		x	construction	$10,315.00	6/17/83	$ 1,920,700	$ 915,672	6/17/15	0.0500	$ 48,737	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,315.00		$ 1,920,700	$ 915,672			$ 48,737	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,920,700	$ 915,672			$ 48,737	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	none	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	none	2
3. Under or (over) accrual (line 2 minus line 1).	$	none	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	none	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	none	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	none	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evenglow Lodge COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008425

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 150,638 B. General Construction Type: Exterior Brick Frame brick and concrete Number of Stories 7

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	long-term care	72,080	1960-1974	$ 77,030	1
2					2
3	TOTALS	72,080		$ 77,030	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	214		1962	1962	$ 103,515	$	various	$	$	$ 103,515	4
5			1963	1963	1,794,010	35,880	50	35,880		1,441,185	5
6			1984	1984	3,561,779	89,044	40	89,044		1,691,842	6
7											7
8											8
	Improvement Type**										
9	building improvements			1963	71,429		20			71,429	9
10	building improvements			1964	542	11	50	11		435	10
11	building improvements			1965	2,354	47	50	47		1,842	11
12	building improvements			1966	528		20			528	12
13	building improvements			1971	402		20			402	13
14	building improvements			1972	210		20			210	14
15	building improvements			1973	345		20			345	15
16	building improvements			1974	1,865		Various			1,865	16
17	building improvements			1977	5,000		10			5,000	17
18	building improvements			1978	6,309		Various			6,309	18
19	building improvements			1979	2,839		Various			2,839	19
20	building improvements			1980	10,103		Various			10,103	20
21	building improvements			1981	1,760		Various			1,760	21
22	building improvements			1982	11,306		5			11,306	22
23	building improvements			1984	48,725		18			48,725	23
24	building improvements			1985	37,039	1,071	Various	1,071		21,922	24
25	building improvements			1986	58,125	718	Various	718		43,493	25
26	building improvements			1987	9,819	491	20	491		8,205	26
27	building improvements			1988	6,792		8			6,792	27
28	building improvements			1989	57,731	3,590	Various	3,590		56,535	28
29	building improvements			1990	129,555		Various			129,555	29
30	building improvements			1991	83,739		Various			83,739	30
31	building improvements			1992	77,791	2,166	Various	2,166		50,473	31
32	building improvements			1993	106,402	4,880	Various	4,880		57,746	32
33	building improvements			1994	12,511	915	Various	915		10,129	33
34	building improvements			1995	433,474	14,600	Various	14,600		265,698	34
35	building improvements			1996	223,735	10,312	20	10,312		89,768	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	building improvements	1997	$ 131,074	$ 6,554	20	$ 6,554	$	$ 40,961	37
38	building improvements	1998	133,503	17,204	various	17,204		92,645	38
39	building improvements	1999	17,677	2,382	various	2,382		9,832	39
40	Landscaping	2000	3,600	360	10	360		1,260	40
41	Elevator Upgrade	2000	117,058	11,706	10	11,706		41,946	41
42	Upgrade Electrical Service	2000	3,908	391	10	391		1,302	42
43	Water Lines to Kitchen	2000	2,369	237	10	237		888	43
44	Building Improvements	2000	1,179	168	7	168		547	44
45	Elevator Upgrade	2001	4,935	493	10	493		1,357	45
46	Cooling System	2001	1,616	323	5	323		754	46
47	Electrical Work	2001	1,837	184	10	184		429	47
48	Decorative Items	2001	4,790	958	5	958		2,106	48
49	Sprinklers	2002	721	36	20	36		66	49
50	Carpet	2002	1,837	262	7	262		481	50
51	Mop Sink	2002	405	58	7	58		106	51
52	masonry and drywall	2002	6,566	168	39	168		295	52
53	drain basin	2002	600	40	15	40		67	53
54	faucets	2002	227	23	10	23		38	54
55	fire access doors	2002	208	14	15	14		23	55
56	masonry	2002	15,335	393	39	393		557	56
57	sidewalk	2002	1,219	81	15	81		102	57
58	room remodel	2002	11,261	289	39	289		337	58
59	steel door dish room	2003	123	10	10	10		10	59
60	replace hot water line	2003	1,475	123	10	123		123	60
61	fire damper actuators	2003	2,171	233	7	233		233	61
62	carpet	2003	414	44	7	44		44	62
63	multi product actuators	2003	521	56	7	56		56	63
64	basement air conditioning	2003	6,620	441	10	441		441	64
65	faucets	2003	213	20	7	20		20	65
66	basement air conditioning	2003	1,300	87	10	87		87	66
67	dishwasher, sink installation	2003	4,281	408	7	408		408	67
68	folding handrail for bathroom	2003	186	11	7	11		11	68
69	game room sound cushions	2003	660	39	7	39		39	69
70	TOTAL (lines 4 thru 69)		$ 7,339,623	$ 207,521		$ 207,521	$	$ 4,421,266	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,339,623	$ 207,521		$ 207,521	$	$ 4,421,266	1
2	kitchen fans	2003	497	30	7	30		30	2
3	asbestos removal	2003	1,610	58	7	58		58	3
4	refloor walk-in coolers	2003	796	28	7	28		28	4
5	replace water pipes	2003	8,189	205	10	205		205	5
6	new lock on exit door	2003	167	4	7	4		4	6
7	tile for basement floor	2003	459		7				7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,351,341	$ 207,846		$ 207,846	$	$ 4,421,591	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 593,747	$ 82,419	$ 82,419	$	3 to 20	$ 384,722	71
72	Current Year Purchases	5,770	749	749		5 to 7	749	72
73	Fully Depreciated Assets	865,248	6,578	6,578		various	865,248	73
74								74
75	TOTALS	$ 1,464,765	$ 89,746	$ 89,746	$		$ 1,250,719	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2001 Dodge Caravan	2001	$ 24,623	$ 4,925	$ 4,925	$	5	$ 11,491	76
77	Patient Transport	1986 Ford Van	1986	34,900					34,900	77
78										78
79										79
80	TOTALS			$ 59,523	$ 4,925	$ 4,925	$		$ 46,391	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,952,659	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 302,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 302,517	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,718,701	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Skyline Apartments	$ 287,907	$ 3,378	$ 63,023	86
87	Land - 202 N. Locust	24,900			87
88	Apartment Building	76,456	4,355	38,721	88
89					89
90					90
91	TOTALS	$ 389,263	$ 7,733	$ 101,744	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	92

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	X
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$ 1,010	$	$ 1,010
2	Books and Supplies			102		102
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			200		200
9	TOTALS		$	$ 1,312	$	$ 1,312
10	SUM OF line 9, col. 1 and 2	(e)	$ 1,312			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 864,747	$ 864,947	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,253)	342,476	453,820	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,900	15,900	6
7	Other Prepaid Expenses	84,760	84,760	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): other receivable	54,050	54,050	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,361,933	$ 1,473,477	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,952,803	1,952,803	12
13	Land	101,930	803,307	13
14	Buildings, at Historical Cost	5,823,667	9,390,773	14
15	Leasehold Improvements, at Historical Cost	1,892,037	1,976,831	15
16	Equipment, at Historical Cost	1,524,288	1,676,237	16
17	Accumulated Depreciation (book methods)	(5,820,445)	(6,146,513)	17
18	Deferred Charges		51,850	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	184,258	184,258	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): contribution receivable	419,008	419,008	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,077,546	$ 10,308,554	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,439,479	$ 11,782,031	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 105,812	$ 105,812	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,655	214,655	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,308	20,308	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	1,400	32
33	Accrued Interest Payable	0	29,929	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 340,775	$ 372,104	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	915,672	915,672	40
41	Bonds Payable	0	2,243,022	41
42	Deferred Compensation	181,798	181,798	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,097,470	$ 3,340,492	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,438,245	$ 3,712,596	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,001,234	$ 8,069,435	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,439,479	$ 11,782,031	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,977,838	1
2	Restatements (describe):		2
3	**Restricted assets**	586,658	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,564,496	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(368,212)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (368,212)	17
	B. Transfers (Itemize):		
18	**change in net assets of Inn**	(2,939,012)	18
19	**net income (loss) of Inn**	(256,038)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3,195,050)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,001,234	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,728,411	1
2	Discounts and Allowances for all Levels	(486,299)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,242,112	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	25,684	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	12,229	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	31,392	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 69,305	23
	D. Non-Operating Revenue		
24	Contributions	151,871	24
25	Interest and Other Investment Income***	96,776	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 248,647	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	unrealized gain on investments	178,588	28
28a	other	2,407	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 180,995	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,741,059	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,519,355	31
32	Health Care	1,842,396	32
33	General Administration	1,348,566	33
	B. Capital Expense		
34	Ownership	358,987	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,967	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,109,271	40
41	**Income before Income Taxes (line 30 minus line 40)****	(368,212)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (368,212)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,342	2,489	$ 65,823	$ 26.45	1
2	Assistant Director of Nursing	3,728	4,067	89,166	21.92	2
3	Registered Nurses	9,555	10,386	230,814	22.22	3
4	Licensed Practical Nurses	14,058	15,998	307,475	19.22	4
5	Nurse Aides & Orderlies	67,919	75,110	797,390	10.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,878	8,953	74,951	8.37	10
11	Social Service Workers	2,025	2,237	25,987	11.62	11
12	Dietician					12
13	Food Service Supervisor	1,896	2,161	33,579	15.54	13
14	Head Cook	2,092	2,190	24,099	11.00	14
15	Cook Helpers/Assistants	39,658	43,991	381,188	8.67	15
16	Dishwashers					16
17	Maintenance Workers	7,367	8,016	95,676	11.94	17
18	Housekeepers	23,192	25,711	204,124	7.94	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	15,037	16,404	199,433	12.16	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,626	2,018	18,344	9.09	31
32	Other Health Care(specify)					32
33	Other(specify) Development	924	1,032	24,505	23.75	33
34	TOTAL (lines 1 - 33)	199,297	220,763	$ 2,572,554 *	$ 11.65	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	251	$ 10,500	li. 1 col 3	35
36	Medical Director	12	2,400	li. 9 col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	900	li. 11 col 3	44
45	Social Service Consultant	23	1,405	li. 11 col 3	45
46	Other(specify)				46
47	Administrator - Donovan Gardner	2,080	48,000	li. 21 col 3	47
48	chaplain	832	11,270	li. 11 col 3	48
49	TOTAL (lines 35 - 48)	3,216	$ 74,475		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	957	$ 42,869	10-3	50
51	Licensed Practical Nurses	1,684	64,079	10-3	51
52	Nurse Aides	580	12,268	10-3	52
53	TOTAL (lines 50 - 52)	3,221	$ 119,216		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
see consultants on page 20			$

TOTAL (agree to Schedule V, line 17, col. 1) $
(List each licensed administrator separately.)

B. Administrative - Other

Description	Amount
	$

TOTAL (agree to Schedule V, line 17, col. 3) $
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Westervelt et al	legal	$ 760
Clifton Gunderson LLP	accounting	13,200

TOTAL (agree to Schedule V, line 19, column 3) $ 13,960
(If total legal fees exceed $2500 attach copy of invoices.)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 186,562
Unemployment Compensation Insurance	5,122
FICA Taxes	192,889
Employee Health Insurance	285,118
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	58,424
employee physicals	5,569
TOTAL (agree to Schedule V, line 22, col.8)	$ 733,684

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,801
Health Care Worker Background Check	
(Indicate # of checks performed)	
licenses and dues	10,509
subscriptions	1,912
advertising and development	14,098
less non-allowable dues	(561)
Less: Public Relations Expense	( )
Non-allowable advertising	(14,098)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,661

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,534
In-State Travel	6,240
Seminar Expense	9,171
less amounts allocated to Inn	(4,796)
less unallowable out of state travel	(2,534)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,615

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Life Services Network $7,249**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **6**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,496** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **39,967**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **25,286**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **yes**
If YES, attach a complete explanation. these costs have been adjusted out.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **none**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Clifton Gunderson, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **audit is not complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.